

Registration

Date: _____ Home Phone: _____

Patient _____
Last Name First Name Initial

Street Address _____
 City _____ State _____ Zip _____
 Sex M F Birthdate _____ Single/Married/Widowed/Separated/Divorced
 Social Security # _____ Driver's License # and State _____
 Insured Name _____ Relationship to Insured _____
 Condition to related (check one) Illness Employment Auto Other
 Emergency Contact: Name _____ Relationship _____
 Home Phone _____ Work Phone _____

Employer	Company Name _____ Occupation _____ Address _____ City _____ State _____ Zip _____ Phone _____
Spouse	Name _____ <div style="display: flex; justify-content: space-between; margin-left: 100px;"> Last Name First Name Initial </div> Birthdate _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____ Phone _____
Patient Insurance Information	Please list any and all insurance coverage you or your spouse has applicable in this case _____ Insurance ID # _____ Major Medical or Auto Insurance : Date of Accident _____ Insurance Company Name _____ Address/Phone _____ Claim # _____ Policy # _____ Effective Date _____
Spouse Co-Insurance Information	MAJOR MEDICAL ONLY Insurance Company Name _____ Address/Phone _____ Policy # _____ Effective Date _____
Referral	How were you referred to this office? <input type="checkbox"/> By a patient - Name _____ <input type="checkbox"/> By Aa physician - Name _____ <input type="checkbox"/> Phone Book - Name _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Employer <input type="checkbox"/> Newspaper <input type="checkbox"/> Other _____
Patient Agreement	ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage with _____ and assign directly to Dailey Chiropractic, Inc. or Dr. Dailey all my medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions _____ Signature of Insured/Guardian Date